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CHAPTER II - INTERMEDIARY COVERAGE AND RELATED ISSUES FOR THE AMBULANCE FEE SCHEDULE

OBJECTIVE

The objective of the Coverage and Related Issues chapter is to provide information on coverage criteria related to the ambulance fee schedule.

Participants will learn about the following in the course of this chapter:

1. Medicare coverage requirements for ambulance services.

2. New aspects of coverage related to the ambulance fee schedule.

COVERAGE REQUIREMENTS

Many of the Medicare coverage requirements for ambulance services have not changed under the ambulance fee schedule. All of the requirements are included in the following instructions:

Medicare Intermediary Manual, Pub. 13-3, Section 3114 and Section 3322
Program Memorandum AB-99-94
Program Memorandum AB-00-88
Program Memorandum AB-00-103
Federal Register, Vol. 65, No. 177, 9/12/00, 55078 – 55100
42 CFR 410.40

CATEGORIES OF SERVICE

Categories of Service

1. **Basic Life Support (BLS)**
2. **BLS-Emergency**
3. **Advanced Life Support 1 (ALS1)**
4. **ALS1-Emergency**
5. **ALS2**
6. **Specialty Care Transport (SCT)**
7. **Paramedic Intercept (PI)**
8. **Fixed Wing Air Ambulance (FW)**
9. **Rotary Wing Air Ambulance (RW)**

The new ambulance fee schedule has seven categories of ground (land or water) ambulance services and two categories of air ambulance services. Paramedic intercept, advanced life support level 2, fixed wing air ambulance, and rotary wing air ambulance assume an emergency condition

Basic Life Support (BLS)

The Basic Life Support category is the provision of BLS services as defined in the National EMS Education and Practice Blueprint for the EMT- Basic, including the establishment of a peripheral intravenous line.

Basic Life Support – Emergency

The Basic Life Support – Emergency category is the provision of BLS services, as specified above, in the context of an emergency response.

An emergency response is one that, at the time the ambulance supplier is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the beneficiary's health in serious jeopardy;
2. impairment to bodily functions; or
3. serious dysfunction to any bodily organ or part.

Advanced Life Support, Level 1 (ALS1)

The Advanced Life Support, Level 1 category is the provision of an assessment by an advanced life support (ALS) provider or supplier **or** the provision of one or more ALS interventions.

An ALS provider/supplier is defined as a provider trained to the level of the EMT-Intermediate or Paramedic as defined in the National EMS Education and Practice Blueprint.

An ALS intervention is defined as procedure beyond the scope of an EMT-Basic as defined in the National EMS Education and Practice Blueprint.

ALS Assessment is an assessment performed by an ALS crew **that results in the determination that the patient's condition requires an ALS level of care**, even if no other ALS intervention is performed.

In the above situation, the EMT-Intermediate or Paramedic must actually ride on the BLS transport for the BLS ambulance provider to bill an ALS service.

Advanced Life Support, Level 1 – (ALS1) Emergency

The Advanced Life Support, Level 1 – Emergency Response category is defined as the provision of ALS1 services, as specified above, in the context of an emergency response.

An emergency response is one that, at the time the ambulance supplier is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the beneficiary's health in serious jeopardy;
2. impairment to bodily functions; or
3. serious dysfunction to any bodily organ or part.

Advanced Life Support, Level 2 (ALS2)

The Advanced Life Support, Level 2 category is:

1. The administration of three or more different medications, **and**

2. The provision of at least one of the following ALS procedures:
   - Manual defibrillation/cardioversion
   - Endotracheal intubation
   - Central venous line
   - Cardiac pacing
   - Chest decompression
   - Surgical airway
   - Intraosseous line

Specialty Care Transport (SCT)

The specialty care transport category is a level of inter-facility service provided for a critically injured or ill beneficiary beyond the scope of the paramedic as defined in the National EMS Education and Practice Blueprint. This is necessary when a beneficiary's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area, e.g., nursing, medicine respiratory care, cardiovascular care, or a paramedic with additional training.

Paramedic Intercept

Paramedic intercept services are ALS services provided by an entity that does not provide the ambulance transport. Under a limited number of circumstances, Medicare payment may be made for these services. For a description of these services see PM B-99-12 dated March 1999 and PM B-00-01 dated January 2000, both titled Paramedic Intercept Provisions of the BBA of 1997.

Fixed Wing Air Ambulance (FW)

The fixed wing air ambulance (airplane) category is services furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate.

Transport by fixed wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility.

Transport by fixed wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

Rotary Wing Air Ambulance (RW)

The rotary wing air ambulance (helicopter) category is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate.

Transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility.

Transport by rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

CERTIFICATION FOR HOSPITAL SERVICES

Providers must meet the certification requirements in the Medicare Intermediary Manual, Pub. 13-3, Section 3322. This section states:

> Certification by a physician in connection with ambulance services furnished by a participating hospital is required. In cases in which the hospital provides ambulance service to transport the patient from the scene of an accident and no physician is involved until the patient reaches the hospital, any physician in the hospital who examines the patient or has knowledge of the case may certify as to the medical need for the ambulance service.

Therefore, providers are required to have a physician certification for emergency and non-emergency transports.

SPECIAL CIRCUMSTANCES

Special Circumstances

1. **Multiple Patients**
2. **Multiple Arrivals**
3. **Service Provided**

In the regulation for the Ambulance Fee Schedule, Medicare policies for some circumstances were clarified.

Pronouncement of Death

The following information explains Medicare policy related to the death of a patient and the resultant effect on payment for ambulance services under the ambulance fee schedule.

The death of a patient is recognized when the pronouncement of death is made by an individual legally authorized to do so by the state where the pronouncement is made. The following three scenarios that apply to payment for ambulance services when the beneficiary dies.

1. If the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, payment may be made; however, neither mileage nor a rural adjustment would be paid.

   If a ground vehicle is dispatched, payment is made for a BLS service.

   If an air ambulance is dispatched, payment is made at the fixed wing or rotary wing base rate, as applicable.

2. Payment is made following the usual rules of payment (as if the beneficiary had not died) when:

   The beneficiary is pronounced dead after being loaded into the ambulance, regardless of whether the pronouncement is made during or subsequent to the transport.

   A determination of "dead on arrival" (DOA) is made at the facility to which the beneficiary is transported.

3. No payment will be made if the beneficiary was pronounced dead prior to the time the ambulance is called.

Multiple Patients

An ambulance may transport more than one patient at a time, for instance, at the scene of a traffic accident. In this situation the payment should be prorated by the number of patients in the ambulance. The following are examples of how to apply this policy.

1. Two patients are transported at one time, one is a Medicare beneficiary and the other is not. Payment is based on one-half of the allowed amount for the level of medically appropriate service furnished to the Medicare patient.

2. If both patients are Medicare beneficiaries, payment for each beneficiary is made based on half of the allowed amount for the level of medically appropriate services furnished to each patient.

Multiple Arrivals

When multiple units respond to a call for services, the entity that provides the transport for the beneficiary should bill Medicare for all services furnished.

For example, a BLS and ALS entities respond to a call and the BLS entity furnishes the transport after an ALS assessment is furnished. The EMT – Intermediate or Paramedic from the ALS service accompanies the patient to the hospital in the BLS ambulance. The BLS entity will bill using the ALS1 rate since an ALS service was furnished. Medicare will pay the BLS entity at the ALS1 rate. The BLS entity and the ALS entity should settle payment for the ALS assessment.

In the above situation, the EMT – Intermediate or Paramedic must actually ride on the BLS transport for the BLS ambulance provider to bill an ALS service.

Service Provided

Medicare pays only for the category of service provided and then only when the service is medically necessary, even if a local government requires an ALS response for all calls.

However, until further notice, when an ALS ambulance provider furnishes BLS or BLS emergency services to a patient, the provider can submit and may be paid for ALS1 or ALS1 emergency services.

MEDICAL REVIEW OF AMBULANCE SERVICES

Claims will be reviewed in accordance with instructions in the Program Integrity Manual, Section 83-6-12. However, additional factors must also be taken into consideration based on the Ambulance Fee Schedule and Program Memorandum AB-99-83.

Medical Review

Other methods contraindicated

Ambulance services are reviewed to determine if they met the ambulance coverage criteria. A determination is made as to whether the patient's condition was such that another method of transportation was contraindicated. Medically necessary transport by ambulance may include:

1. Emergency situations, e.g., accidents, injury, acute illness
2. Need for restraints
3. Unconsciousness or shock
4. Requiring emergency treatment during the trip
5. Requiring immobilization, i.e., fracture or the possibility of a fracture
6. Sustained acute stroke or myocardial infarction
7. Experiencing severe hemorrhage

Please note this list is not all-inclusive.

REVIEW CONSIDERATIONS RELATED TO THE AMBULANCE FEE SCHEDULE

Because of the ambulance fee schedule billing requirements, additional factors must be taken into consideration during the medical review process.

Review Under Fee Schedule

1. **Category of Service**
2. **Medical Conditions List**
3. **Non-emergency Transport**

Category of Service

The documentation will be reviewed to determine if the category of service billed to Medicare is the category of service that was provided, and that it was the category of service that was medically necessary. Until further notice, however, when an ALS ambulance provider furnishes BLS or BLS emergency services to a patient, a claim for ALS1 or ALS1 emergency services can be submitted.

Medical Conditions List

Addendum A (Medical Conditions List) was provided in the NPRM to solicit comments on the need for such a list in the support of the claims process. The conditions list was not a part of the negotiated rule committee agreement. We did **not** integrate this into the automated claims process but will consider doing so based on comments on the NPRM. Therefore, the condition list could be a future adjustment to the claims process but will not be discussed in detail at this time.

Addendum A can be used as a guide in determining medical necessity. This list identifies medical conditions, not diagnoses, which generally require ambulance services and the appropriate level of care. It includes non-emergency conditions; emergency medical conditions, traumatic and non-traumatic; and emergency and non-emergency conditions that warrant inter-facility transport services.

Non-Emergency Transports

Ambulance transportation is covered when it meets medical necessity requirements described above. One of the primary determining factors of medical necessity for non-emergency transport is the status of whether the patient is "bed confined." For bed confinement, the following criteria must be met:

Bed confinement criteria is met when the beneficiary is:

1. **Unable to get up from bed without assistance**
2. **Unable to ambulate**
3. **Unable to sit in a chair or wheelchair**

1. The beneficiary is unable to get up from bed without assistance;
2. The beneficiary is unable to ambulate; and
3. The beneficiary is unable to sit in a chair or wheelchair.

All three of the above-listed components must be met in order for the patient to meet the requirements of the definition of "bed confined." The term applies to individuals who are unable to tolerate any activity out of bed. This term is not synonymous with "bed rest," "non-ambulatory," or "stretcher-bound."

These criteria, as defined, are not meant to be the sole criteria in determining medical necessity. They are factors to be considered when making medical necessity determinations.

Non-emergency services may be:

1. Scheduled, or
2. Unscheduled

Some non-emergency response services are actually scheduled. **Scheduled** services are generally regularly scheduled transportation for the diagnosis or treatment of a patient's medical condition (e.g., transportation for dialysis.)

Unscheduled services generally pertain to non-emergency transportation for medically necessary services, e.g., from one facility to another.